TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ved A Aggarwal MD

Respondent Name
Twin City Fire Insurance Co

MFDR Tracking Number
M4-17-0004-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
September 1, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The testing is done "to detect any form of drug abuse/monitor medication for Pain Management."

Amount in Dispute: $635.83

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The services in dispute were denied for absence of preauthorization."

Response Submitted by: The Hartford, 300 S. State St., One Park Place, Syracuse, NY 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 28, 2015	Clinical Laboratory Services	$635.83	$94.54

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider
   - 293 – This procedure requires prior authorization and none was identified

- AUTH – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Pre-Authorization was not obtained and treatment was rendered without the approval of treating doctor.
- W3 – Additional payment made on appeal/reconsideration

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requester seeks additional reimbursement for clinical laboratory services rendered on October 28, 2015 in the amount of $635.83.

   The requester states, "The Physician (Kent Mitchell MD) services are for Pain Management and the Physician Claim was filed separately and was reimbursed for his services for the OFFICE VISIT which was the actual visit that led up to the physician ordering services for Laboratory to "Detect any form of Drug Abuse / Monitor Medication."

   The insurance carrier denied disputed services with claim adjustment reason code "293 – This procedure requires prior authorization and none was identified" and "AUTH – Pre-authorization was not obtained and treatment was rendered without the approval of treating doctor."

   The prior authorization requirement is detailed in 28 Texas Administrative Code 134.600 (p) which states in pertinent part,

   > Non-emergency health care requiring preauthorization includes:
   >
   > (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;
   >
   > (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;
   >
   > (3) spinal surgery;
   >
   > (4) all work hardening or work conditioning services requested by:
   >
   > (A) non-exempted work hardening or work conditioning programs; or
   >
   > (B) division exempted programs if the proposed services exceed or are not addressed by the division's treatment guidelines as described in paragraph (12) of this subsection;
   >
   > (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:
   >
   > (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
   >
   > (i) Modalities, both supervised and constant attendance;
   >
   > (ii) Therapeutic procedures, excluding work hardening and work conditioning;
   >
   > (iii) Orthotics/Prosthetics Management;
   >
   > (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and
   >
   > (B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;
   >
   > (C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:
   >
   > (i) the date of injury; or
   >
   > (ii) a surgical intervention previously preauthorized by the insurance carrier;

(6) any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care;

(7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program;

(8) unless otherwise specified in this subsection, a repeat individual diagnostic study:

(A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline; or

(B) without a reimbursement rate established in the current Medical Fee Guideline;

(9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);

(10) chronic pain management/interdisciplinary pain rehabilitation;

(11) drugs not included in the applicable division formulary;

(12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits);

(13) required treatment plans; and

(14) any treatment for an injury or diagnosis that is not accepted by the insurance carrier pursuant to Labor Code §408.0042 and §126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury).

Review of the submitted information finds the respondent presented insufficient to support the need for authorization as detailed in the above. Therefore, the Division finds the carriers' denial is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. The Division rules for clinical laboratory services are found in 28 Texas Administrative Code 134.203, "Medical Fee Guideline for Professional Medical Services." The applications that system participants are to follow is found at §134.203(b) which states in pertinent part,

For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits;

Review of the submitted DWC60 finds the following codes are in dispute:

- 82542 - Column chromatography, includes mass spectrometry, if performed (eg, HPLC, LC, LC/MS, LC/MS-MS, GC, GC/MS-MS, GC/MS, HPLC/MS), non-drug analyte(s) not elsewhere specified, qualitative or quantitative, each specimen
- G6056 - Assay of nicotine
- 83992 - Phencyclidine (PCP)
- G0431 - Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter
- G6030 - Assay of amitriptyline
- G6031 - Assay of benzodiazepines
- G6032 - Assay of desipramine

- G6034 - Assay of doxepin
- G6036 - Assay of imipramine
- G6037 - Assay of nortriptyline
- G6040 - Assay of alcohol (ethanol); any specimen except breath
- G6041 - Alkaloids, urine, quantitative
- G6042 - Assay of amphetamine or methamphetamine
- G6044 - Assay of cocaine or metabolite
- G6045 - Assay of dihydrocodeinone
- G6046 - Assay of dihydromorphinone
- G6052 - Assay of meprobamate
- G6053 - Assay of methadone
- 80171 - Gabapentin, whole blood, serum, or plasma

Review of the National Correct Coding Initiatives Policy Manual, Chapter 12, found at www.cms.gov, finds the following:

> *HCPCS code G0431 (drug screen... by high complexity test method..., per patient encounter) is utilized to report drug urine screening performed by a CLIA high complexity test method. This code is also reported with only one (1) unit of service regardless of the number of drugs screened.*
>
> *For a single patient encounter only G0431 or G0434 may be reported. The testing described by G0431 includes all CLIA high complexity urine drug screen testing as well as any less complex urine drug screen testing performed at the same patient encounter.*

Based on the above, the Division finds code G0431 was billed and is therefore eligible for payment. All other billed codes are not separately payable as they were performed at the same patient encounter.

3. The fee is calculated per 28 Texas Administrative Code §134.203(e) which states,

> The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:
>
> (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and,
>
> (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.

Review of the 2015 Clinical Diagnostic Laboratory Fee Schedule finds an allowable for $75.63. No professional component applies.

The maximum allowable reimbursement is calculated as follows, $75.63 x 125% = $94.54. This amount is recommended.

4. The total allowable reimbursement for the services in dispute is $94.54. The carrier previously paid $0.00. The remaining balance of $94.54 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $94.54.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $94.54, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		October 18, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.